FRESNO UNIFIED SCHOOL DISTRICT

DISTRICT COUNTER-PROPOSAL

FTA NEGOTIATIONS

February 13, 2014

ARTICLE 18 - FRINGE BENEFITS

1. General Provisions:

A. The District shall provide District paid coverage (less the applicable employee contribution) for bargaining unit members and eligible dependents as specified within this Article and in the FUSD Employee Health Care Plan Document.

B. The District's Employee Health Care Plan Document shall be considered a part of this article. Any revisions, modifications, additions, deletions, termination and/or change of health care providers as identified in the plan document dated July 1, 2005, shall be subject to the authority of the Joint Health Management Board (JHMB).

C. The District shall provide District paid life insurance coverage for bargaining unit members. The amounts of District furnished life insurance for employees will remain as specified in the Standard Insurance Co. Policy contract effective April 1, 1986. Supplemental units of insurance and dependent coverage are available at the bargaining unit member's expense.

D. A bargaining unit member must be employed 50% or more to be eligible for FUSD's Health and Life Insurance Plans.

E. Bargaining unit members who provide a full year of service to the District (i.e., the complete Duty Year as defined in this agreement) shall be entitled to continued District-paid coverage under all District paid programs for twelve (12) months, commencing with the first month the unit member receives such benefits for the Duty Year. These conditions also apply to unit members whose employment terminates following the last day of the school year and before the commencement of the following school year.

F. Bargaining unit members, who terminate paid service during the school year, shall have their calendar year of Health and Plan coverage prorated to equal the percentage of the service year worked.

G. Bargaining unit members returning from Board-approved leave shall be re-enrolled, with their dependents, with no health history requirement (except for the District Life Insurance Plan) or wait until the next enrollment period.

H. The District shall not prohibit any bargaining unit members from enrolling all eligible dependents as defined by the eligibility requirements of the contracted specifications of the FUSD Employee Health Care Plan Document.

I. Employees and eligible dependents must enroll within thirty-one (31) days of eligibility. Unit members enrolling or adding dependents shall effect coverage the first day of eligibility provided the request for coverage is made within thirty-one (31) days of eligibility.

The District shall provide one 60-day open enrollment period each year beginning January 10 for all bargaining unit members and eligible dependents not currently enrolled in the existing FUSD Employees Health Care Plan. The open enrollment period will also be the time in which plan coverage (Dental and Vision) may be changed.

2. Joint Health Management Board (JHMB)

A. A Consultant and Plan Administrator shall be selected and funded by JHMB, who will remain in a contractual and/or employment relationship with the District.

B. Contracts and Compensation for the Consultant and Plan Administrator shall be recommended by JHMB, but subject to approval by the Board of Education. Such approval shall not be arbitrarily or unreasonably withheld.

C. Reporting, reports and disclosures of the Consultant and Plan Administrator shall be as established by the JHMB.

D. The JHMB will, as soon as possible, establish written procedures for conducting its functions as set forth in this Agreement. Such procedures shall include:

1) Voting procedures, including absentee voting.

2) Establishing regular meeting dates.

3) Establishing subcommittees.

4) The agendizing and prioritizing of JHMB activities.

5) The establishment of terms for JHMB members. Such terms shall promote stability and continuity of membership in order to foster expertise in the subject matter of the JHMB.

E. Labor and Management shall each have one (1) vote on the JHMB.

F. Labor representation shall be proportional to membership in determining the one (1) labor vote. Management representation shall be determined by the District. The decision making process of the JHMB shall be:

1) Consensus; if consensus cannot be reached, (2) applies.

2) If consensus is not reached the following is an example of the weighted vote for employee groups.

Example

The voting structure is weighted with each group maintaining a percentage of the weighted vote based on the number of eligible active employees in the unit as a portion of all represented eligible active employees in the District. For example, if FTA represents 4,352 employees out of a total of 6756 represented eligible employees in the health plan, FTA's voting weight would be 64.4 percent; if CSEA represented 1717 of these same 6756 represented eligible employees, CSEA's voting weight would be 25.4% percent; SEIU's eligible active employees would be 8.5% weighted vote; and BTC's 115 eligible employees would be 1.7% weighted vote.

G. There shall be binding arbitration of any JHMB deadlocked votes; provided however the arbitrator(s) shall have no authority to increase the District's contribution to the Health Fund. Rather, such an increase can only occur, if at all, through subsequent negotiated agreements and ratification thereof by all parties. Upon agreement by Labor and Management (i.e., each casting its single vote in the affirmative), such arbitration may be "Expedited Arbitration" on a case by case basis. The cost of arbitration is to be borne by the Health Fund. Arbitrators shall be selected from a list provided by the California State Mediation and Conciliation Service.

H. All Plan Design modifications, including but not limited to co-pays, deductibles, premium contributions and assessments, and selection, addition or termination of health plans/providers for all active and retired employees (regardless of age) shall be made by the JHMB (unless a deadlock goes to arbitration), and implemented upon JHMB action/arbitration decision without the need for further negotiations and/or ratification by the parties. Any premium contributions shall be accomplished through automatic payroll deduction for employees and through direct contributions from retirees.

I. All vendor Contracts are to be negotiated by JHMB, subject to approval by the Board of Education. Such approval shall not be arbitrarily or unreasonably withheld.

J. The JHMB will assume full responsibility for all retiree health benefits, including the funding of unfunded liability as required by law, and the maintenance of prudent IBNR's, both of which shall be in accordance with actuarial recommendations. The JHMB will set as a target allocation of $2million annually and will allocate not less than $1 million annually from the Health Fund toward such unfunded liability.

3. Health Fund

Beginning with the 2005-2006 school year, the District's initial contribution to the Health Fund shall be the actual Health Fund expense (not including IBNR's) as reflected in the 2004-2005 unaudited actuals. The District's contribution rate per eligible employee shall be determined by dividing the total actual 2004-2005 health and welfare expenditures by the average number of eligible employees in the Health Plan in 2004-2005. The District shall contribute the same per eligible employee amount for the average number of all eligible active employees unrestricted-funded, restricted-funded, special education-funded, in the Health Plan in 2004-2005. Following the District's initial contribution as set forth above the District shall adjust on a monthly basis, its contribution to reflect the actual number of active eligible employees.

For example, assuming the following:

Total eligible active employees (all funding sources) =7113

Total District expenditures for health and welfare for 2004-2005

(All funding sources) = $97,085,337

District contribution amount per eligible active employee = $13,649.

The District's current annual maximum contribution toward the Health Plan benefits provided to each active eligible unit member of $13,649 shall be increased by $500, effective beginning the 2014-2015 insurance year. The automatic inflator set forth below in Article 18, Section 5, "Health and Welfare and Compensation" will be modified to address the Local Control Funding Formula based on the net percentage change each fiscal year in the base grant revenue received by the District. The specific details will be subject to further discussion.

A. Current medical IBNR's shall remain as IBNR's in the Health Fund.

4. Procedures Regarding Potential Underfunding of Health Fund

A. The JHMB shall report to the District and all employee associations on a quarterly basis regarding the status of the Health Fund.

B. Specifically, such reports shall indicate whether actual expenditures from all components of the Health Plan are projected to exceed budgeted Health Fund revenues (the "shortfall"). This determination shall be made based on claims experience and expenses to date, projected according to objective, industry-based and historical trends to yield an annualized projection of total expenditures.

C. If the shortfall is less than three percent (3%), the JHMB shall act immediately to increase eligible employee and/or retiree contributions or assessments, and/or modify plan design pursuant to Section 2 (H) above. Such action shall negate the shortfall within the fiscal year.

D. If the shortfall is three percent (3%) or more, the Health Plan Reserve Assessment shall automatically and immediately be increased for all eligible active employees and eligible pre-65 year old retirees. Such increase shall be in the amount necessary to negate the shortfall within the fiscal year. In determining the amount of the increase the JHMB shall base its decision on the information and recommendations of the JHMB's consultant. If the JHMB cannot agree on the amount of the increase within fifteen (15) days of the consultants' recommendations, the consultants' recommendations shall be implemented.

E. JHMB actions and/or automatic assessments shall apply as set forth in paragraphs (C) and (D) above regarding any month in which a projected shortfall is determined to exist.

F. If any of the foregoing actions do not negate the shortfall in the same fiscal year, and the District must temporarily fund the remaining shortfall, such amount shall be deducted from the District's contribution to the Health Fund for the following year.

5. HEALTH AND WELFARE AND COMPENSATION

A. Commencing with the 2006-2007 school year and continuing year to year unless negotiated otherwise, the District's contribution to the Health Fund as set forth in Section 3 of this Article "Health Fund," shall be automatically increased by the percentage figure representing the effective, ongoing unrestricted dollar increase to the District's base revenue limit (BRL) actually received by the District in the applicable school year, including the ongoing unrestricted COLA, any ongoing unrestricted deficit reduction or equalization, and/or any other ongoing adjustment to the District's funded BRL/ADA identical in effect to a COLA, and accounting for declining or increased enrollment.

B. The parties shall utilize the BRL as set forth in the Governor's May Revise if the final State Budget Act BRL is not known in time to implement effective July 1. The contribution to the Health Fund shall be adjusted (up or down) based on the final BRL percentage, as defined in paragraph (A) immediately above, contained in the State Budget Act.

C. The foregoing shall constitute the District's maximum contribution to the Health Fund.

The JHMB shall be responsible for implementing any changes necessary to ensure that health and welfare costs in excess of this level of contribution shall be borne by eligible active employees and eligible retirees in the Health Plan through plan design and or employee/retiree contribution/assessment changes, and/or any other JHMB actions as described in Section 2 paragraph H "Joint Health Management Board (JHMB)." Such changes must be adopted by the JHMB and implemented effective July 1 annually, except for any changes made pursuant to Section 4 of this Article (Procedures Regarding Potential Underfunding of Health Fund).

D. For example, assume the new (year two) statewide average BRL increase is 3.5%, and a calculation of the District's effective BRL increase is 3.0%, based on the actual, realized dollar increase in BRL income. Assume the prior school year (year one) District contribution to the Health Fund was $55 million (unrestricted). Assume health and welfare costs increase by 10% (by $5.5 million). The District's contribution would be increased by $1.65 million ($55 million multiplied by 3%). The JHMB would be responsible for implementing changes necessary to generate an additional $3.85 million ($5.5 million minus $1.65 million = $3.85 million).

Note: The example in D above assumes that the same number of eligible active employees is in the Health Plan in years one and two. However, the precise calculation would be based on the number of eligible active employees in the Health Plan for year two multiplied by the District's contribution amount per eligible active employee (see 2005-2006, "Plan Design" paragraph C above); as such contribution amount has been increased by the hypothetical 3%. The District's contribution per active eligible employee to the health fund shall not be less than the amount set forth in Section 3 of this Article "Health Fund."

E. Compensation: The parties agree that the increased dollar amount already contributed to the Health Fund in year two as set forth above, shall automatically be deducted from the additional BRL dollars actually received by the District that are available for negotiations over potential salary increases for the applicable school year.

1) Notwithstanding the provisions of paragraph E immediately above, the parties agree that the District will increase its contribution to the health and welfare fund pursuant to this Article 18 of the Agreement for the 2006-2007 and 2007-2008 school years; however, there will be no separate deduction of this amount from the salary increases set forth in Article 50.

F. The foregoing BRL contribution to the Health Fund shall continue in effect upon expiration of this three-year Agreement until the parties reach agreement on a successor negotiated contract.

6 RETIREE BENEFITS - MEDICAL HEALTH PLAN

The District shall provide paid Medical Health Plan benefits for retirees in accordance with the following provisions:

A. An eligible retiree is one who:

1) Has been hired prior to January 1, 1982 and who has served ten (10) years of service in the Fresno Unified School District;

2) Has been hired after January 1, 1982 and has served sixteen (16) years of service in the Fresno Unified School District;

3) Has been hired prior to January 1, 1982 whether or not he/she resigned from the District and was rehired between January 1, 1982 and July 1, 1994 and who has at least a total of ten years of service in the Fresno Unified School District;

4) Has been hired after July 1, 1994 regardless if he/she was hired before January 1, 1982 and who has served sixteen years of service in the Fresno Unified School District;

5) Retirement Benefits and Eligibility for Employees Hired On or After July 1, 2005: The following eligibility requirements and District-provided retirement benefits shall apply to employees hired on or after July 1, 2005.

Minimum age: 60

- Minimum years of service with the District: 25
- Benefit coverage for employee and spouse
- Benefit coverage to age 65 or age of Medicare eligibility if revised by law (no post-65/post-age of Medicare eligibility benefits)*

* The District shall provide up to five (5) years of retiree benefits regardless of whether the minimum age of Medicare eligibility is revised by law. In such event, the District's minimum age of eligibility for retiree benefits shall be amended accordingly. For example, if the Medicare age of eligibility is increased to 67 years of age, the District's minimum age of eligibility for retiree benefits shall automatically be increased to 62.

These modifications shall not apply to laid off permanent or probationary employees who were hired on or before June 30, 2005, and are rehired by the District within the applicable statutory reemployment period since such a break in service is disregarded. These modifications shall also not apply to temporary employees who were hired on or before June 30, 2005 and who have been released and subsequently reemployed within a 24 month period. Instead, such rehired employees shall be eligible for and receive retirement benefits pursuant to conditions that exist for employees hired prior to July 1, 2005.

6) Has reached the age of fifty-seven and one-half (57-1/2) years, except in the case of disabilitants. A disabilitant, as so certified by STRS, becomes eligible for this benefit immediately if such disabilitant has had ten (10) years' service in the District. Board-approved leave shall be counted in the years' service requirements for the benefit.

B. An eligible dependent(s) is defined as meeting the eligibility requirements of the FUSD Employee Health Care Plan Document.

C. Eligibility is further determined by both the retiree and/or dependent(s) enrolling in Medicare Part "A" when first qualified for such coverage through Social Security Eligibility at no cost to the retiree and/or dependents. Additionally, it is required that all retirees and/or dependent(s) enroll in Medicare Part "B" upon becoming eligible.

D. If a retiree receiving this benefit should predecease a spouse, then the benefit will continue for said spouse provided all applicable requirements of these provisions are met.

E. To receive this benefit, a retiree must not be in a paid status with the District.

F. All references to "Medicare" refer to the Federal Medicare Law as described in Title l8 of the Social Security Act of 1964. An eligible dependent(s) is defined as meeting the eligibility requirements of the FUSD's Employee Health Care Plan Document.

G. Eligible bargaining unit members hired prior to July 1, 2005, who retire after the age of fifty (50) and who maintain coverage under the FUSD's Employee Health Care Plan at their own expense shall be eligible for District-paid coverage at age fifty-seven and one-half (57& ½) in accordance with the other provisions in this article.

H. Eligible bargaining unit members hired after June 30, 2005, who retire after the age of fifty (50) and who maintain coverage under the FUSD's Employee Health Care Plan at their own expense shall be eligible for District-paid coverage at age sixty (60) in accordance number A (5) of this section.

I. Disputes arising over the application of this article shall not be subject to the "Grievance Procedure" as printed within this Agreement. This shall not be construed so as to prevent the submission of such disputes to the appropriate court of law.

J. Hold Harmless: Should future District action to implement assessments and contributions from current retirees based on this collective bargaining agreement be challenged in an appropriate forum, and if the Association is named as a party in such action, the District

hereby agrees to defend, hold harmless and indemnify the Association for any adverse final judgment and any reasonable attorney's fees and costs incurred by the Association. The District shall have the exclusive right to decide and determine whether any such action shall be compromised, resisted, defended, tried or appealed.

7. Plan Design

A. There will be a clear eligibility statement for those who qualify for the health plan. Eligibility will be verified each calendar year. Spouses of employees who work for another employer which provides health insurance coverage may only access the FUSD plan as secondary coverage.

B. Eligibility of dependent children shall be based on birth order rule and shall be verified each calendar year. The parent whose birthday comes first in the year shall be responsible for covering dependent children through employer provided health coverage.

C. Cross-Covered Participants (Active and/or retired employees and spouses are both FUSD employees and retirees): Cross-covered participants, through the annual open enrollment process, will have the opportunity to choose whether they desire to retain cross-covered status.

Those cross-covered participants who elect to retain this status shall be required to cross-enroll themselves and eligible dependent children (if applicable) under each participant's plan. Each participant is required to pay the established monthly two party or family premium, as applicable, for the coverage(s) chosen.

Those current cross covered participants who elect through open enrollment not to remain cross-covered, shall receive the same benefit levels (plan design) and incur the same monthly premium expenses as all other non cross-covered participants.

D. No Opting Out: All eligible District employees shall be required to participate in the Health Benefits Plan and shall be required to pay the monthly contributions and assessments, at least at the employee only level for any plan(s) or coverages.

E. Other Clarifications: The following first four clarifications shall apply to all employees and retirees who are not cross-covered as set forth in paragraph 3 above. The fifth bullet applies to all employees and retirees including those who are cross-covered as set forth in paragraph 3 above.

- ! No co-pays apply to annual deductibles or the out of pocket maximums.
- ! The deductible will not apply to out of pocket maximum.
- ! The $100 emergency room co-pay shall be applied to each and every visit to the emergency room (waived only if admitted).
- ! The $10/$35 (Generic/Brand) prescription co-pays assumes the same $10/$35 co-pay for a 30 day maximum supply at retail, 90 day, or a 180 day (maintenance only) maximum at mail order.
- ! Prescription benefits include and are subject to manufacturer quantity limit restrictions in accordance with maximum quantities that may be dispensed in a single prescription. This applies to all participants including cross covered.

F. Effective April 1, 2011 the following monthly contributions and assessment shall apply:

All eligible active employees and eligible pre-65 year-old retirees

	Plan A	Plan B
Employee Only	$60.00	$30.00
Employee + Children	$75.00	$40.00
Employee + Spouse	$120.00	$60.00
Employee + Family	$130.00	$70.00

All Eligible Active Employees and Eligible Retirees Up to Age 75

Health Plan Reserve Assessment: In addition to the monthly contributions provided above, all eligible active employees and pre-65 year old retirees shall contribute a Health Plan Reserve Assessment of $10.00 per month. All eligible post-65 retirees and eligible dependents (spouses and children) shall contribute $10.00 per month each, up to a maximum of $40.00 per month. However, these monthly contributions shall continue only until the retiree and/or dependent reaches age 75, at which time the post-75 year-old retiree/dependent shall not be required to make any monthly contributions. The funds generated from this Assessment shall be placed in a Health Plan Reserve to offset current and future health care cost increases as needed. If the Joint Health Management Board determines such funds are not needed for this purpose, the Board may determine to reduce, rebate or refund such assessment. All retiree plan participants age 65 and over who are eligible for Medicare shall designate Medicare as their primary insurance coverage.

G. Effective April 1, 2011, the following shall be in effect:

Calendar Year Annual Deductible:	Plan A $250/$500 in network (individual/family) $750/$1500 out of network	Plan B $250/$500 in network (individual/family) $750/$1500 out of network
Co-insurance	Plan A 90% in network 70% out of network	Plan B 80% in network 60% out of network
Annual out of pocket maximum	Plan A $2000/$4000 (individual/family)	Plan B $5000/$10000 (individual/family)
Lifetime Maximum	$1.5 million	
Emergency Room	$100 (waived only if admitted. eliminates $500 accident benefit)	
Urgent Care Facility visit co-pay	$35.00	
Outpatient surgical procedures co-pay	$100	
Doctor office visit co-pay	Plan A $15	Plan B $25
Prescription co-pay	$10 generic/ $35 name brand 30 - 90 days max retail, 180 days (maintenance only)	

Eliminate coverage for non-sedating antihistamines
(now available over the counter)
Eliminate coverage for proton pump inhibitors
(now available over the counter)

Chiropractor Office visit co-pay $5/28 visits